Building Multicultural Women's Health: Setting an Agenda for Los Angeles

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Achieving Equitable Health

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Thursday, May 24, 2007

5 Leading Causes of Death, U.S., 2003, Female

	1	2	3	4	5
All races	Cardiovascular	Cancer	Cerebrovascular	Chronic lower respiratory	Alzheimer's
White	Cardiovascular	Cancer	Cerebrovascular	Chronic lower respiratory	Alzheimer's
Black	Cardiovascular	Cancer	Cerebrovascular	Diabetes	Nephritis
American Indian	Cardiovascular	Cancer	Accidents	Diabetes	Cerebrovascular
Asian or Pacific Islander	Cancer	Heart	Cerebrovascular	Accidents	Diabetes
Hispanic	Cardiovascular	Cancer	Cerebrovascular	Diabetes	Accidents
White, non-Hispanic	Cardiovascular	Cancer	Cerebrovascular	Chronic lower respiratory	Alzheimer's
Black, non-Hispanic	Cardiovascular	Cancer	Cerebrovascular	Diabetes	Nephritis

Heron, M. P., & Smith, B. L. (2007). *Deaths: Leading causes for 2003* (No. DHHS Publication (PHS) 2007-1120): National Center for Health Statistics.

National Landmark Reports Highlighting Cancer Disparities Problem

Pre - 1980 1986 1989 1996 1999 2001 2002 2003

Survival Statistics

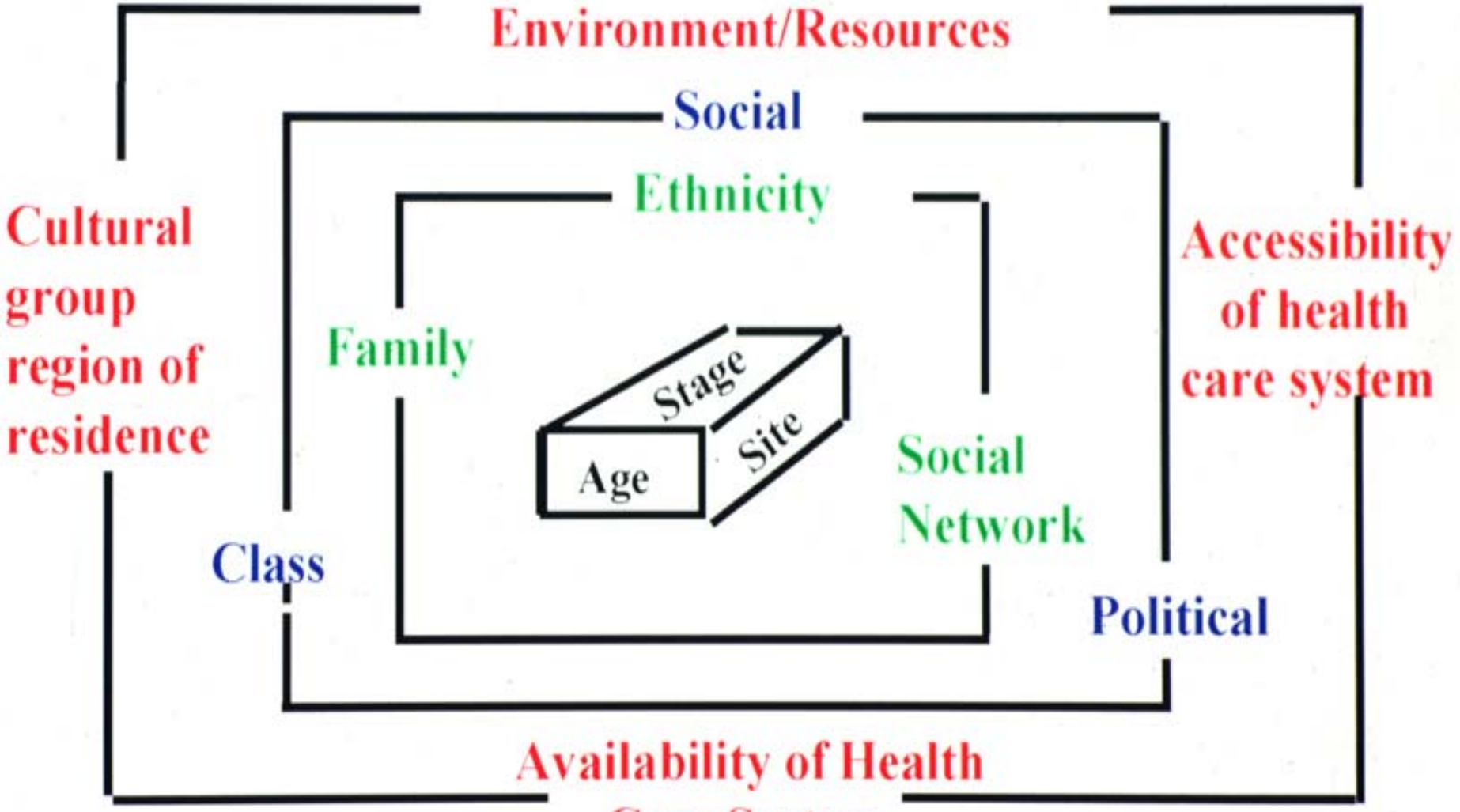
- 60%
- 43%
- 20%

Titanic Survival Rates by Passenger payment levels

- 1st Class
- 2nd Class
- 3rd Class

Disease always occurs within a context of human circumstances, including economic status, social position, culture and environment.

Ecologic Determinants of Illness Response



M Kagawa-Singer, 1999

These human circumstances largely determine whether survival is possible as well as the quality of survival.

The most robust measure of health disparities is who dies too soon.

Three Major Questions

What populations have poor survival?

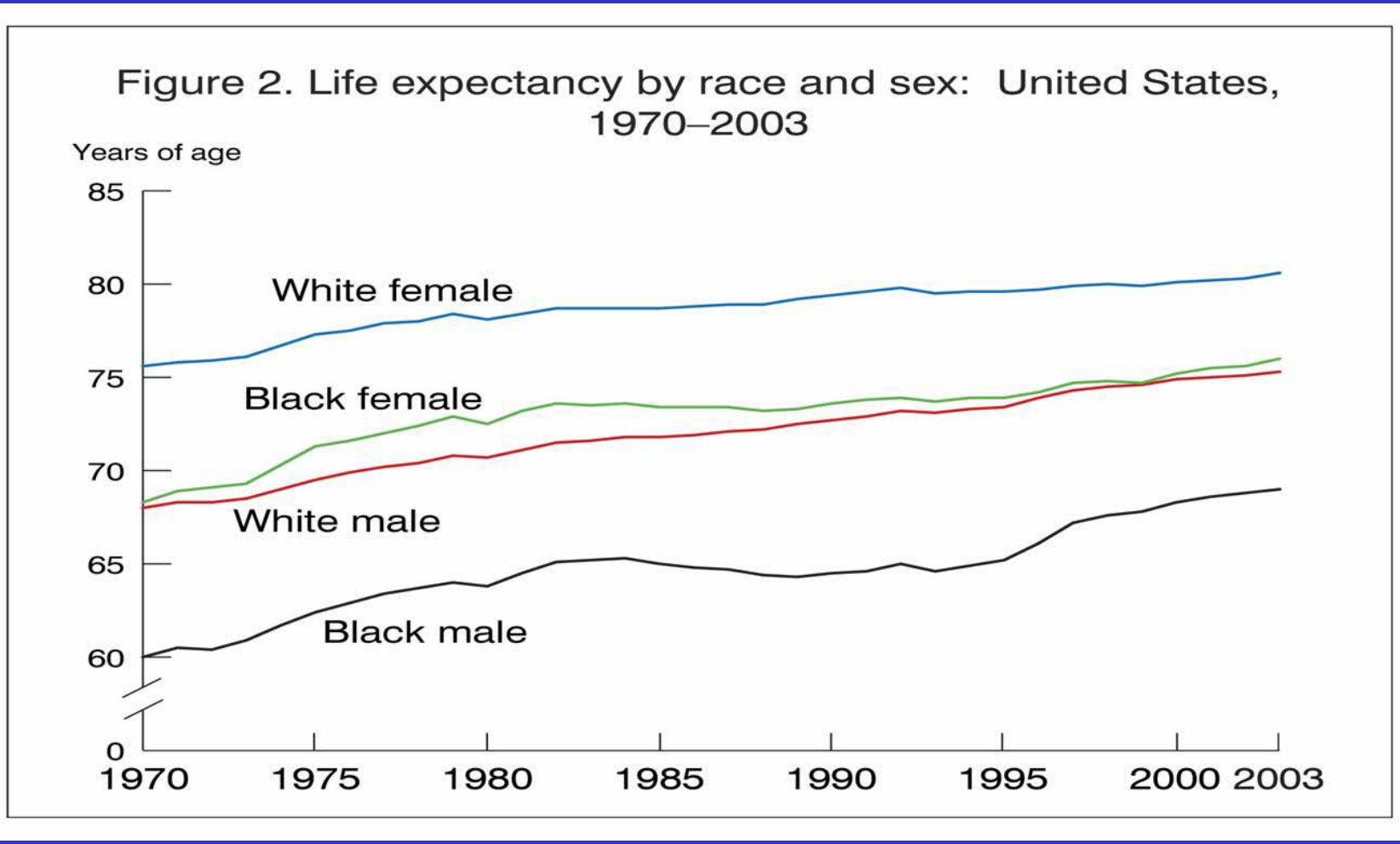
What are the causes of disparities in survival?

How can we eliminate disparities?

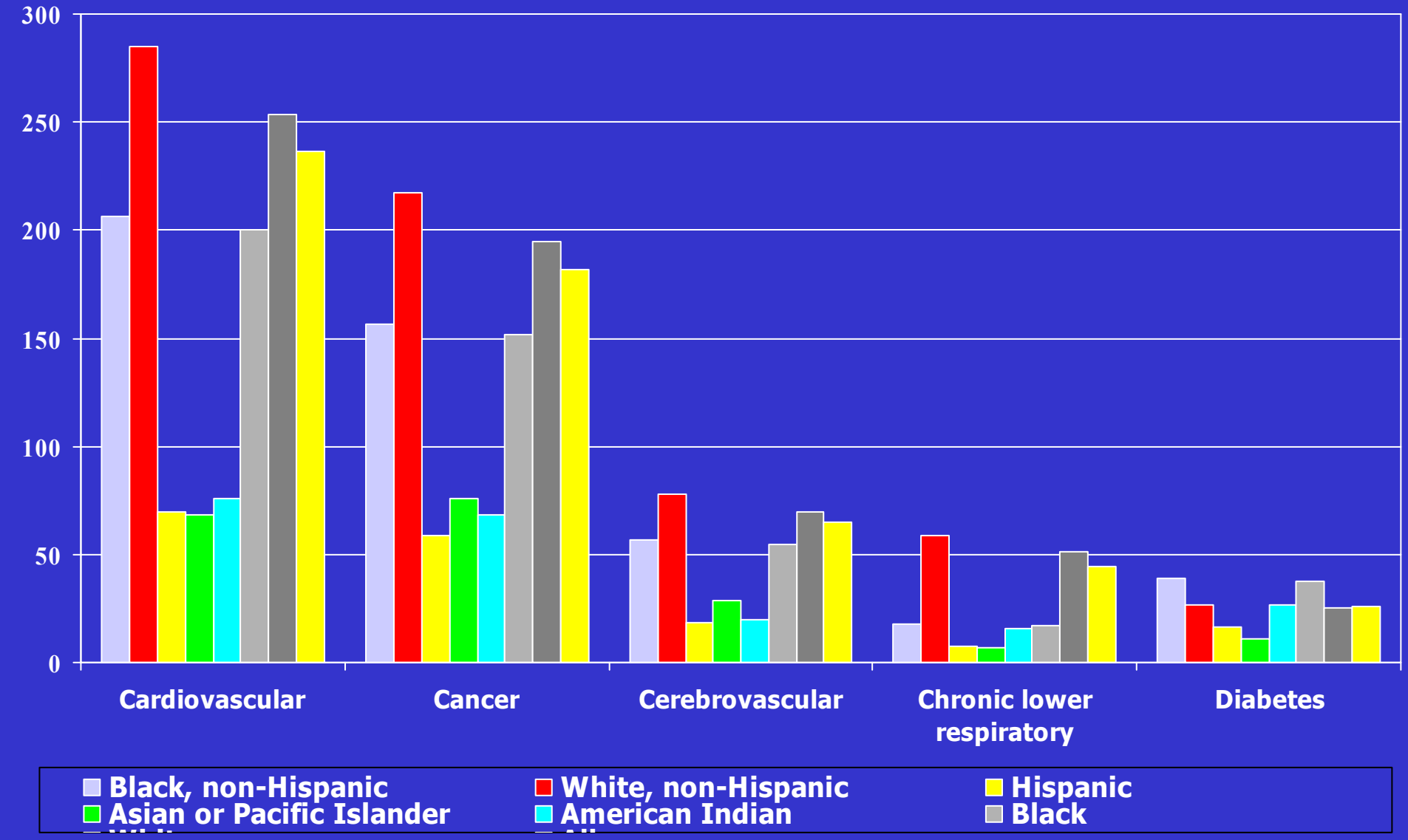
What populations have poor survival?

Life Expectancy at Birth – USA (1970-2003)

(CDC/National Center for Health Statistics Report 2006)

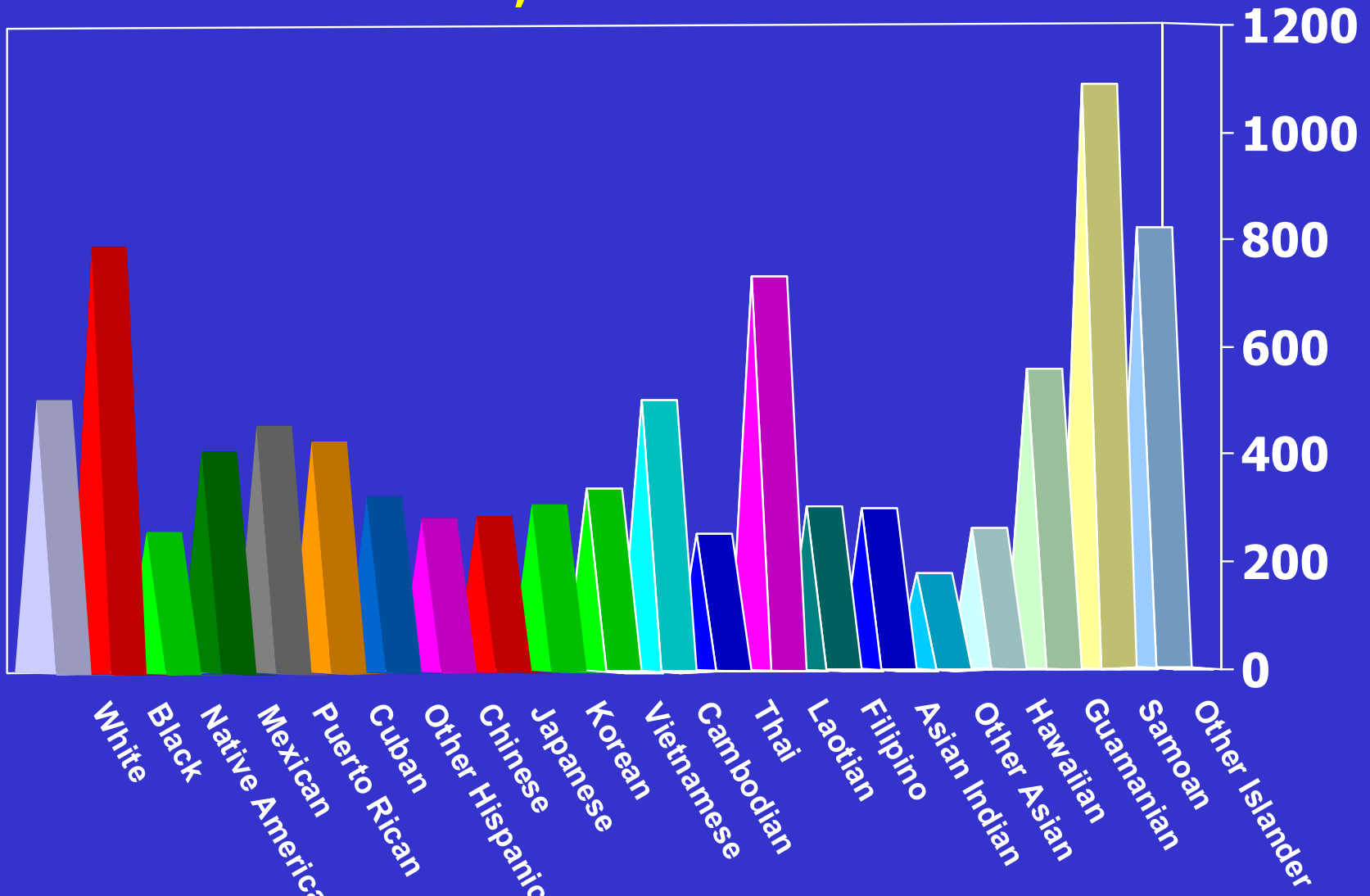


Leading Causes of Death, U.S., 2003, Female



Heron, M. P., & Smith, B. L. (2007). *Deaths: Leading causes for 2003* (No. DHHS Publication (PHS) 2007-1120): National Center for Health Statistics.

Age-Adjusted Death Rates Due to All Causes, California 2000



What are the causes of health disparities?

Causes of Most Chronic Illnesses

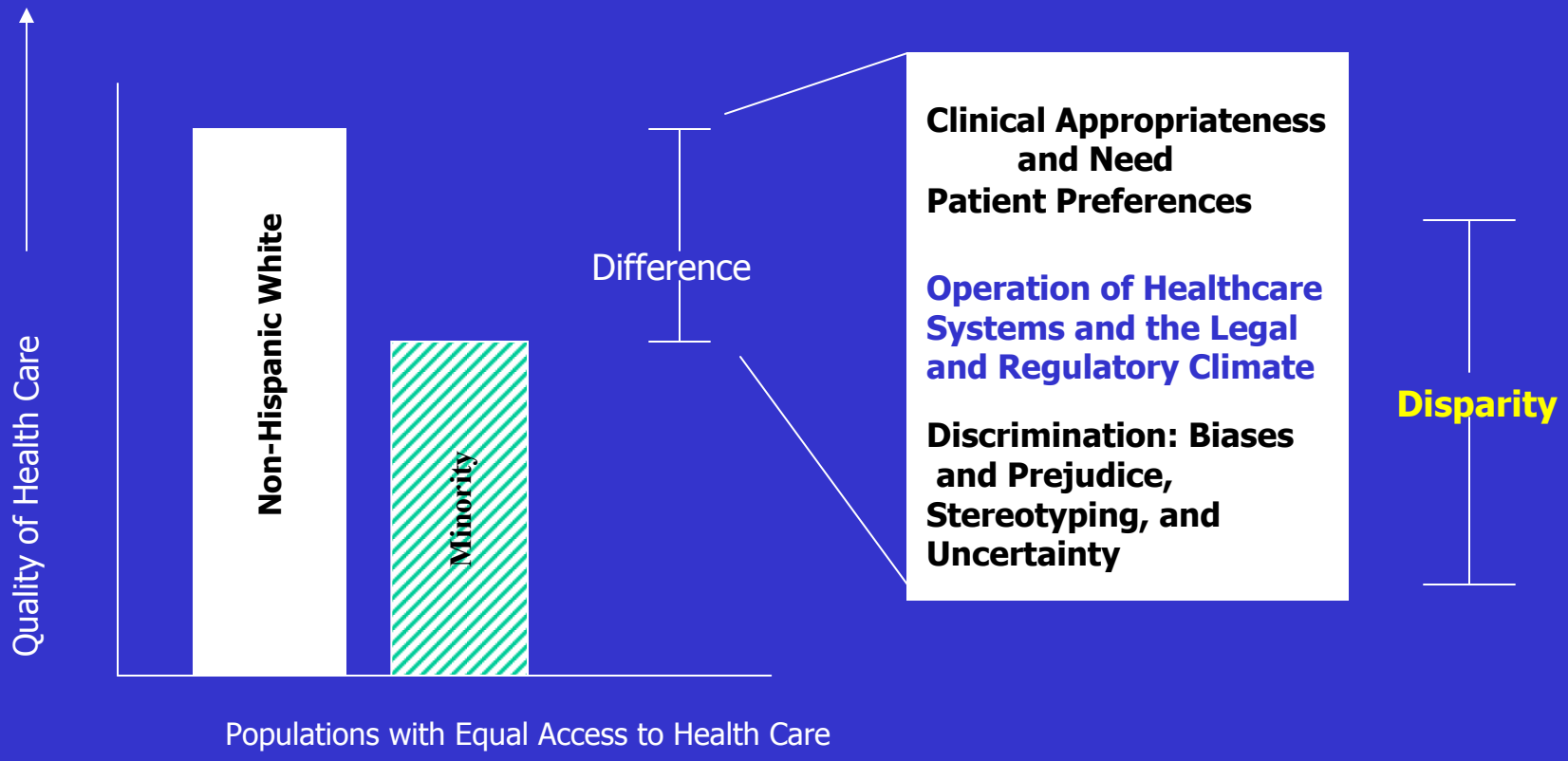
- 5% due to genetics
- 95% due to:
  - lifestyle
  - environment
  - diet
- Culture forms lifestyle

Therefore – attention to cultural differences makes a great deal of difference in decreasing the cancer burden

Cultural Groups –

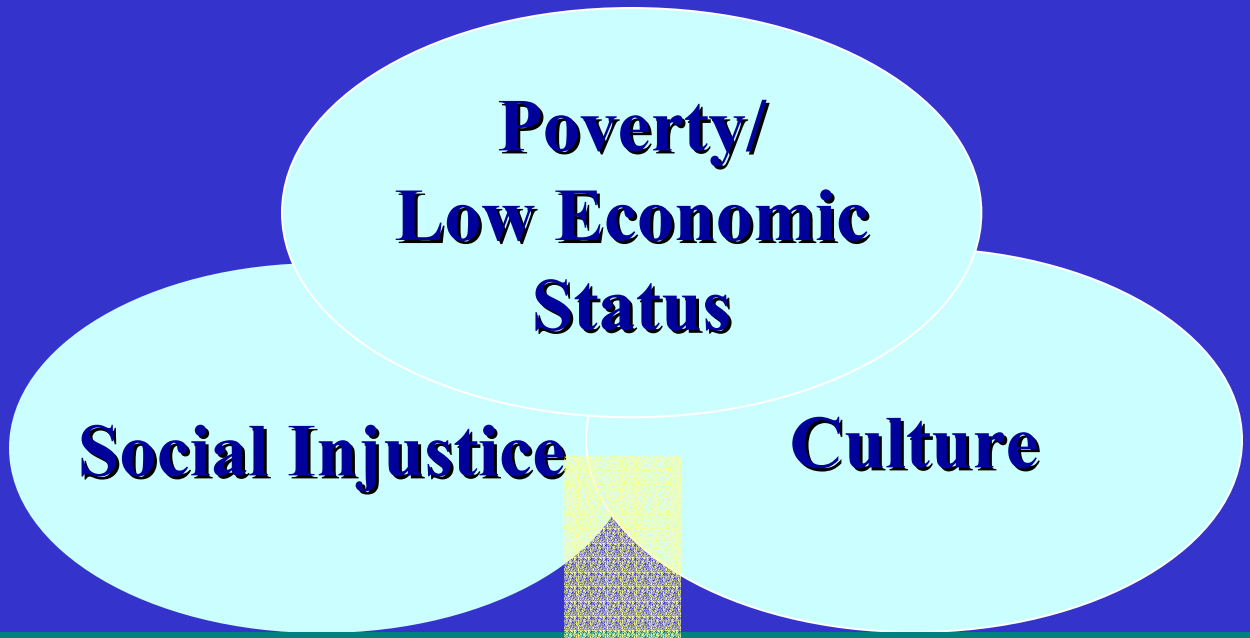
No data = no policy = no programs

Figure 1: Differences, Disparities, and Discrimination: Populations with Equal Access to Health Care*



* Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, IOM, 2002

Causes of Health Disparities



Possible Influence on Gene Environment Interaction

Prevention | Early Detection | Diagnosis/ Incidence | Treatment | Post Treatment/ Quality of Life | Survival and Mortality

Freeman, Adapted from *Cancer Epidemiology Biomarkers & Prevention*, April 2003

Race

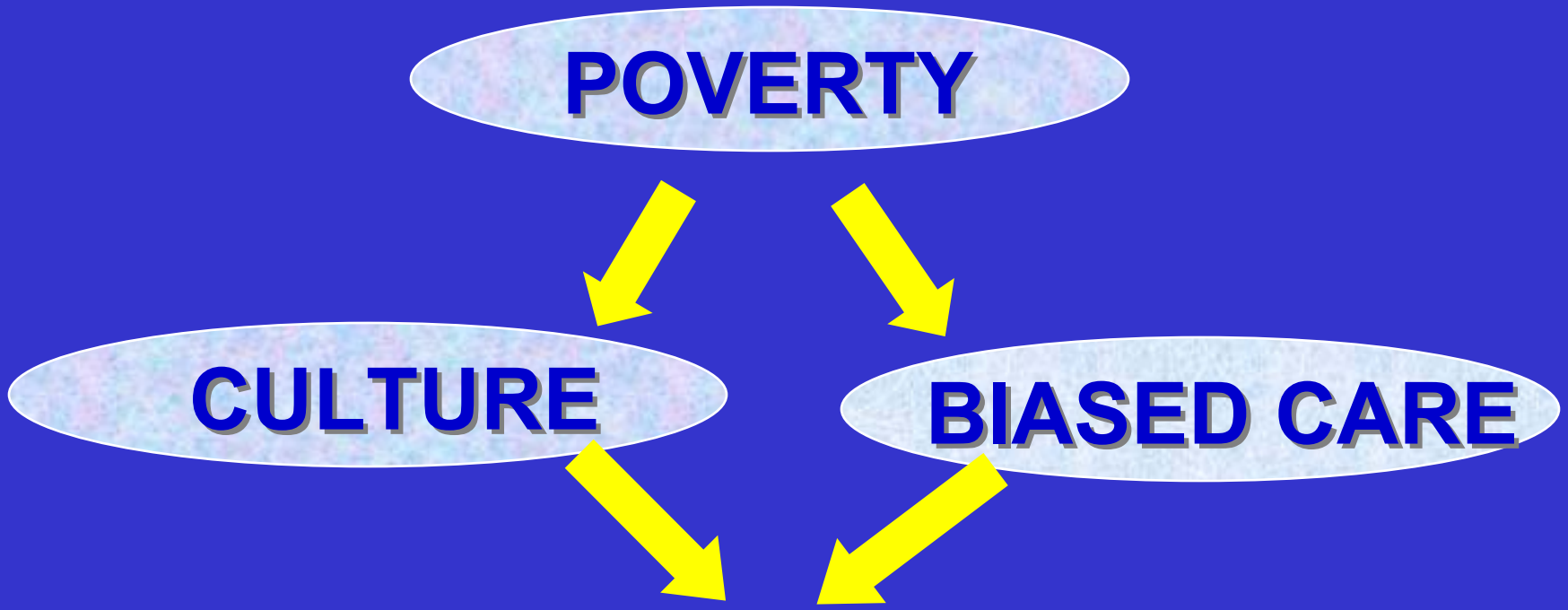
Perhaps the single most defining issue in the history of American society

In our society
we see, value, and
behave toward one
another through a
powerful lens of race.

Biomedical and social scientists have demonstrated that these attributed and imposed factors are not innate to racial categories

NO SCIENTIFIC EVIDENCE EXISTS FOR THE EXISTENCE OF RACES.

Economic status, culture, and genetics have, to a large extent, been disentangled from race.



Inadequate physical and social environment	Inadequate information and knowledge	Risk-promoting lifestyle, attitude, behavior	Diminished access to health care

DECREASED SURVIVAL

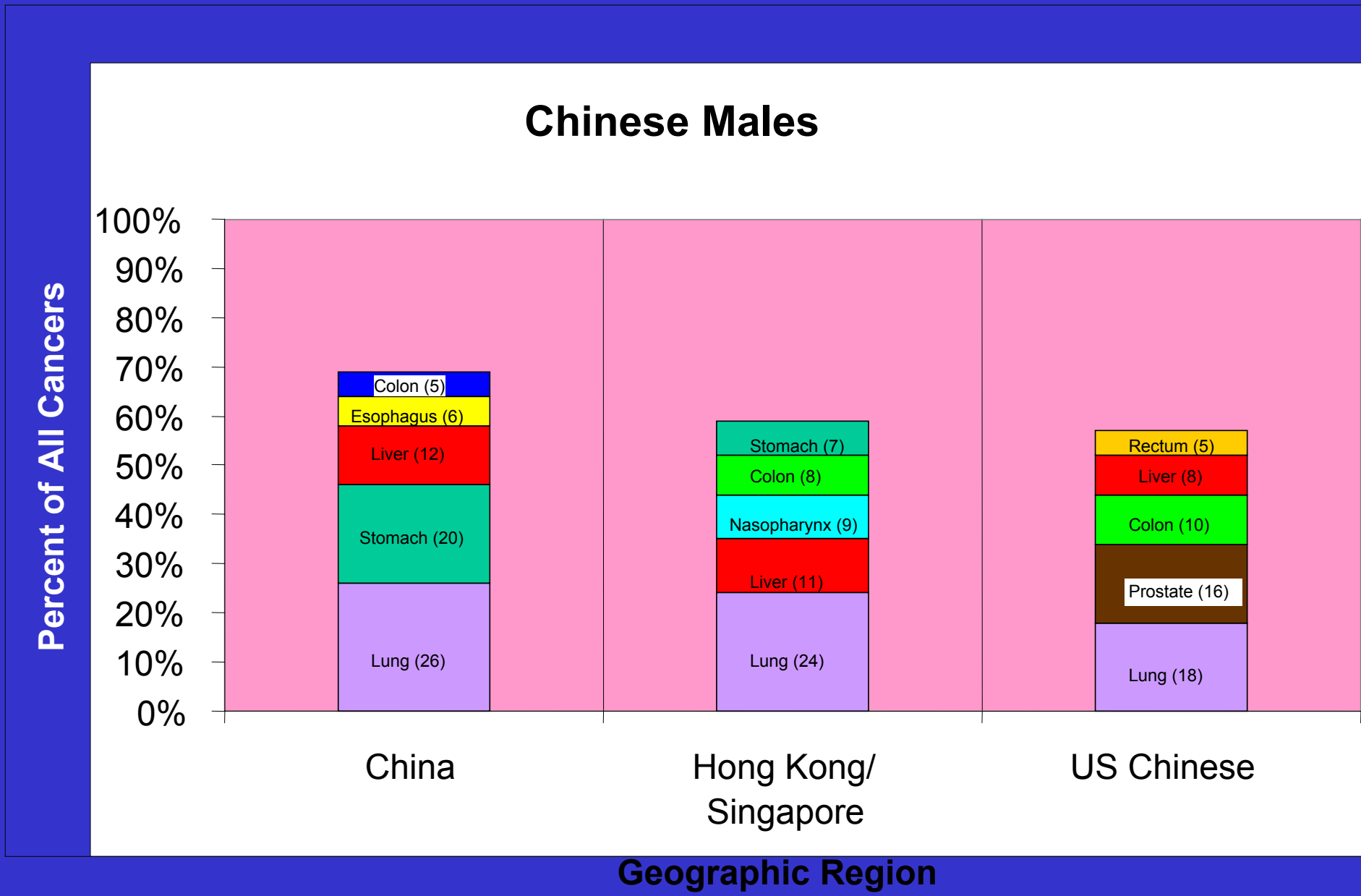
Freeman, H.P., 1989 – revised MKS 2007

Culture may augment or diminish poverty's expected negative effects.

Study of Cultural Differences

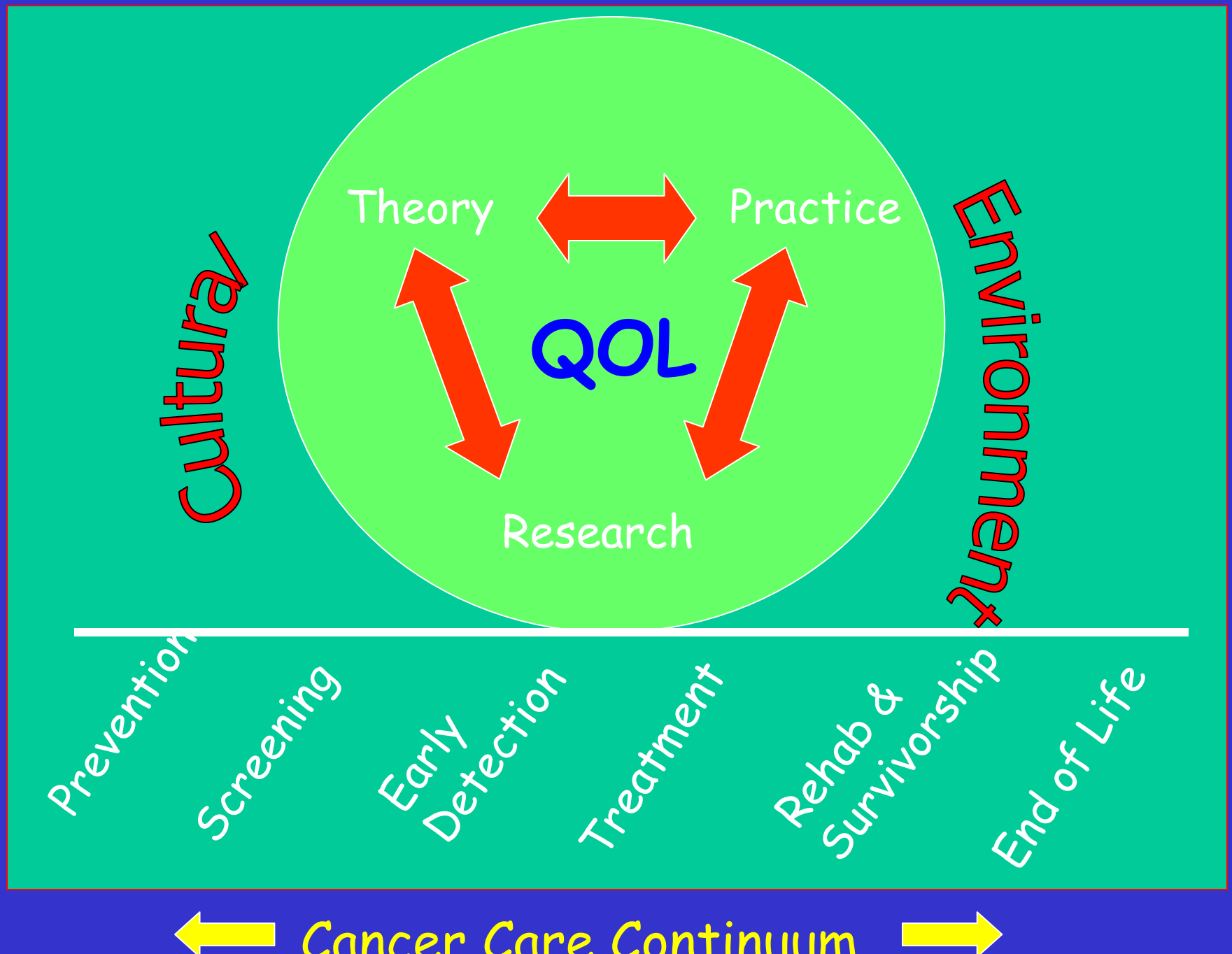
- Differential vulnerability
- Differential protection

Five Cancers contributing to overall cancer incidence burden in males by race/ethnicity and geography



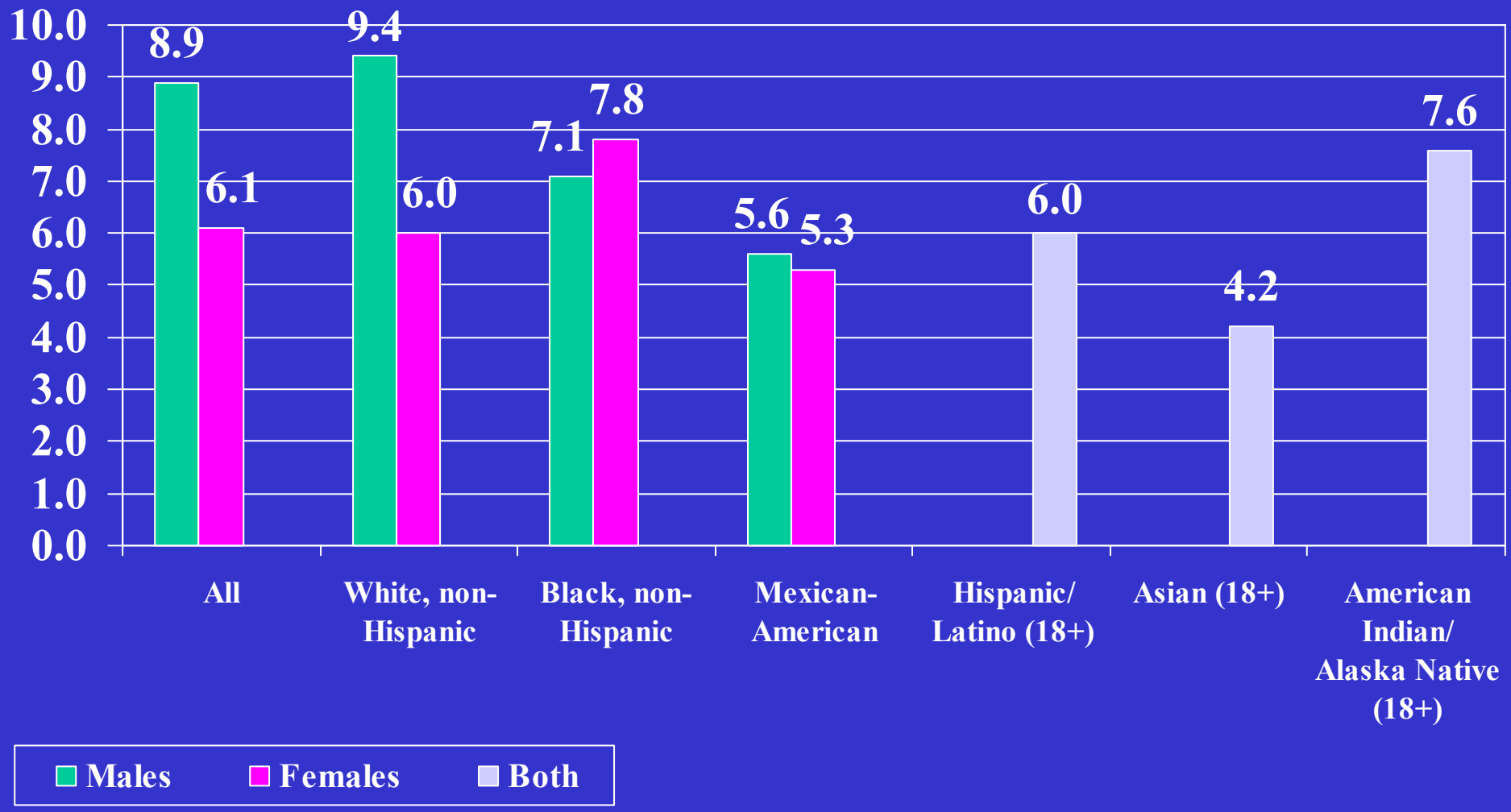

CHINA GATE
CHINESE & THAI FOOD
FOOD TOGO
CHINA GATE
Taco Village #4
TACOS, BURRITOS, TORTA
BEEF
PORK
Cummings
OPEN
OPEN


BAIL BOND
AGENCY
Home of the
KOSHER Style BURRITO
Coca-Cola
Coca-Cola
'98 7 17


Theory
Practice
QOL
Research
Cultural
Environment
Prevention
Screening
Early Detection
Treatment
Rehab & Survivorship
End of Life
Cancer Care Continuum

Coronary Heart Disease

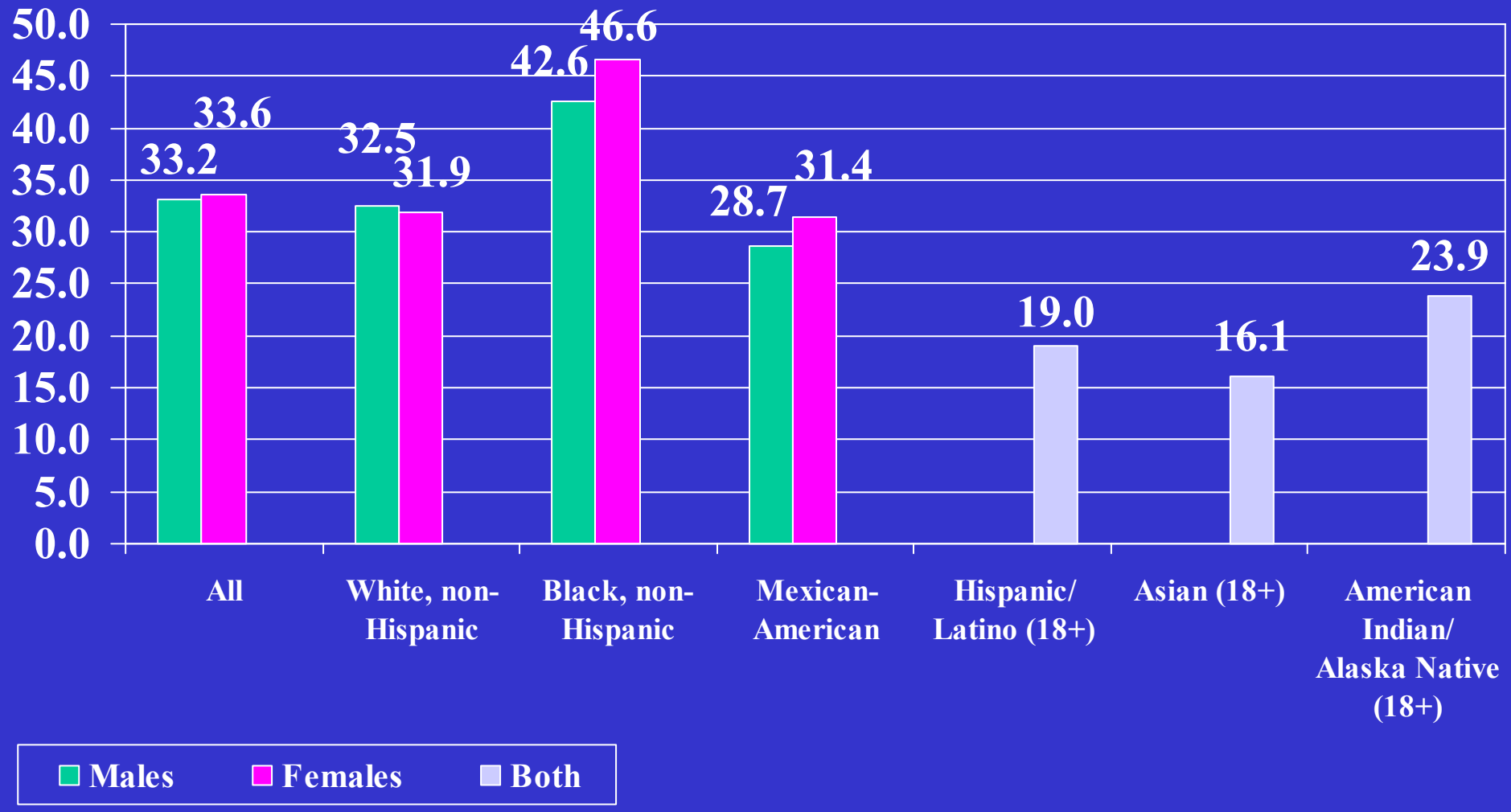
Prevalence (%) Age 20+, U.S., 2004



American Heart Association. (2007). Heart Disease and Stroke Statistics--2007 Update. *Circulation, 115*, e69-e171. Table 3-1.

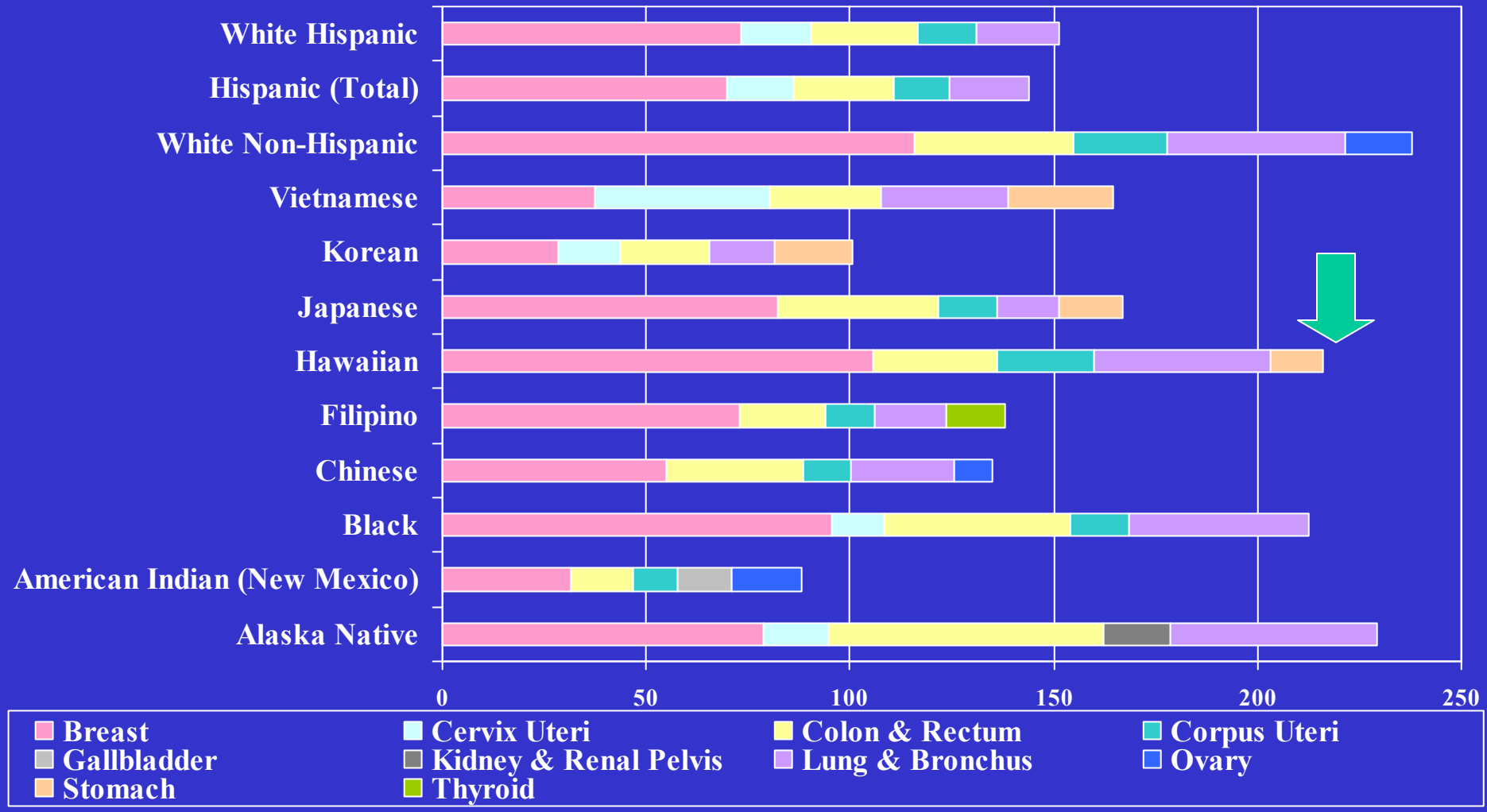
High Blood Pressure

Prevalence (%) Age 20+, U.S., 2004



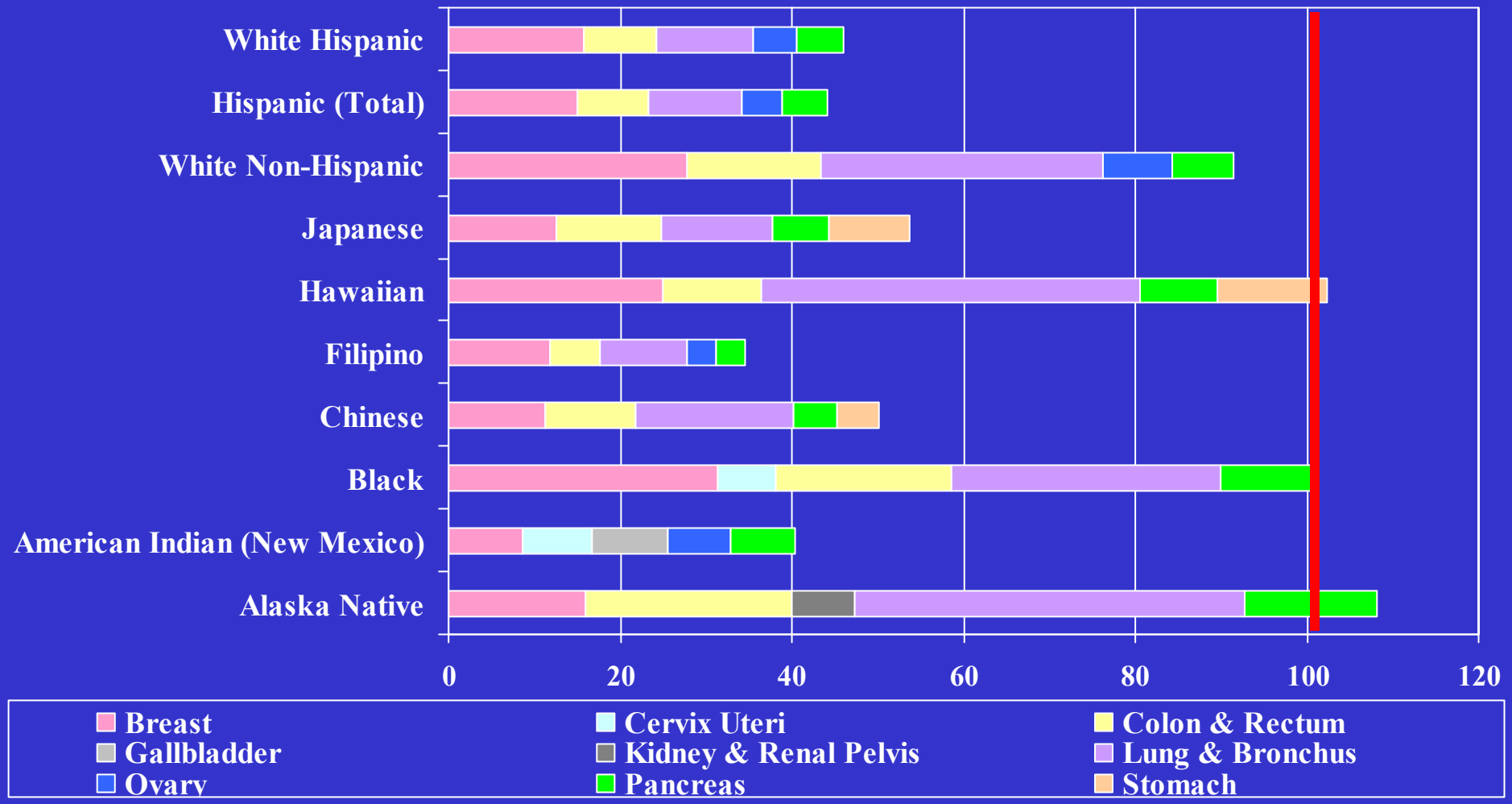
American Heart Association. (2007). Heart Disease and Stroke Statistics--2007 Update. *Circulation, 115*, e69-e171. Table 5-1.

FIVE Most Frequently Diagnosed Cancers
SEER Cancer Incidence Rates for Women, 1988-1992



Miller, B. A., Kolonel, L. N., Bernstein, L., Young Jr, J. L., Swanson, G. M., West, D., et al. (1996). *Racial/Ethnic Patterns of Cancer in the United States 1988-1992* (No. NIH Pub. 96-4104). Bethesda, MD: National Cancer Institute.

FIVE Most Common Types of Cancer Deaths
United States Mortality Rates for Women, 1988-1992



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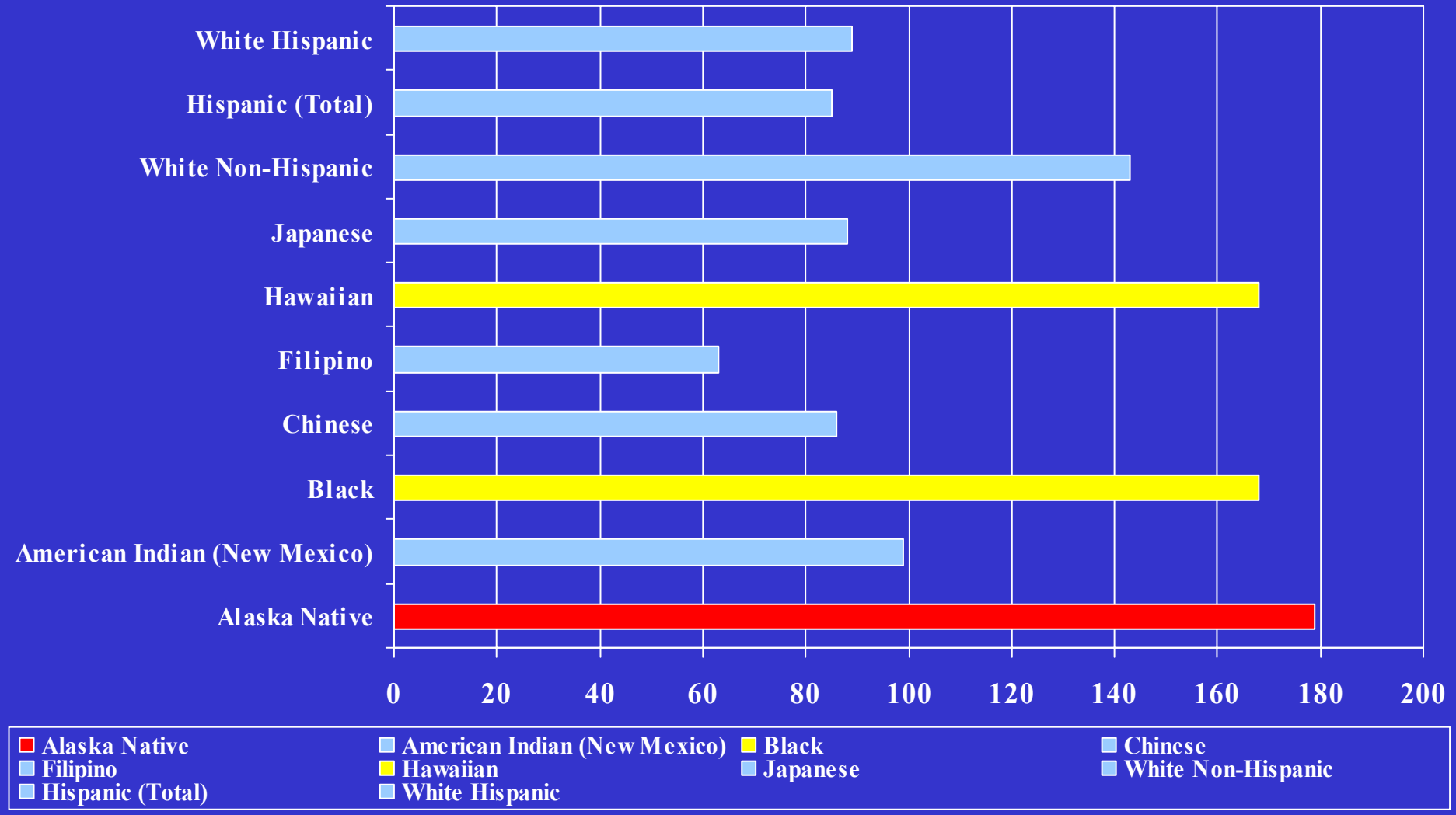
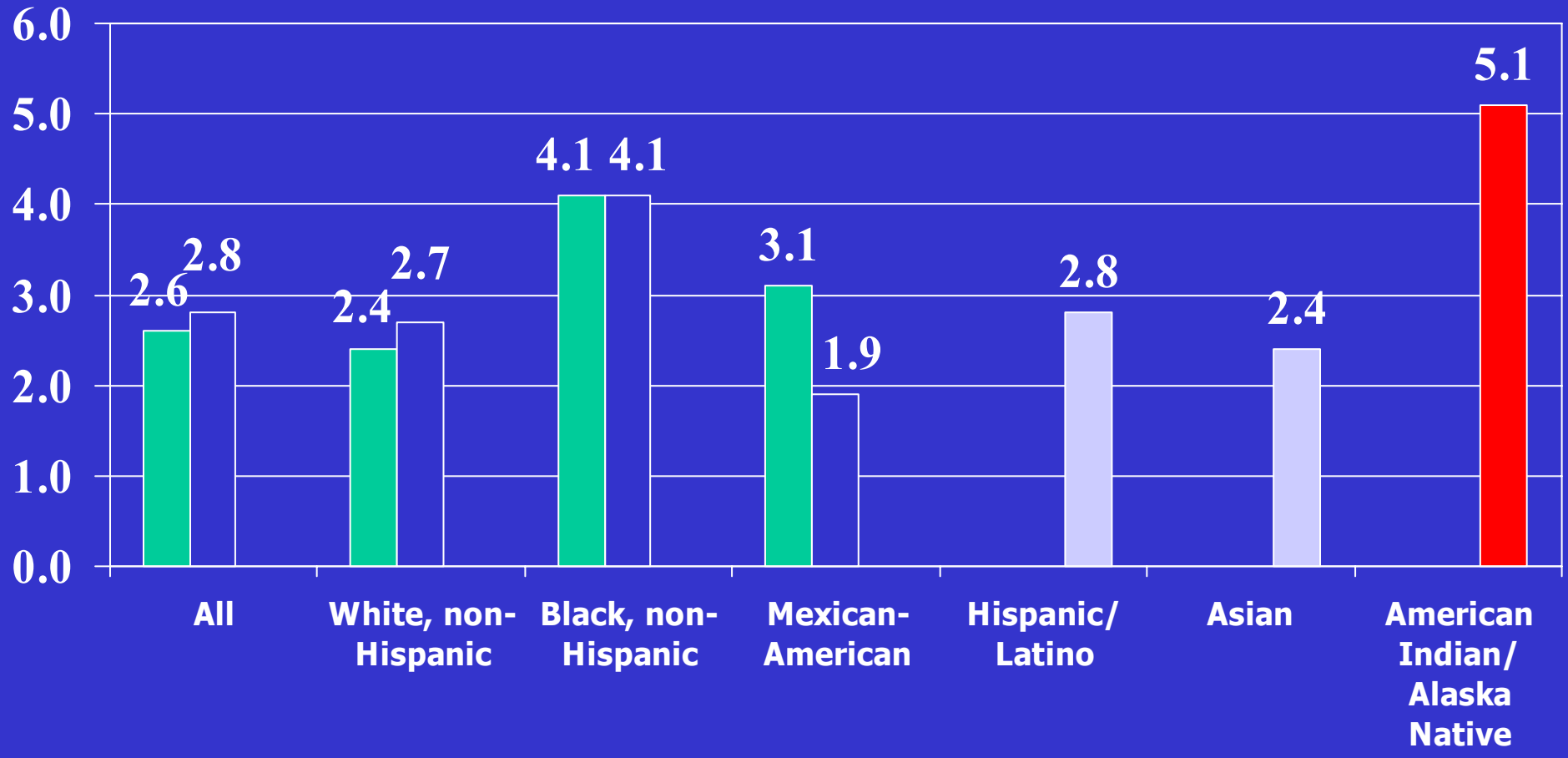
ALL CANCERS COMBINED
United States Mortality Rates for Women, 1988-1992



Miller, B. A., Kolonel, L. N., Bernstein, L., Young Jr, J. L., Swanson, G. M., West, D., et al. (1996). *Racial/Ethnic Patterns of Cancer in the United States 1988-1992* (No. NIH Pub. 96-4104). Bethesda, MD: National Cancer Institute.

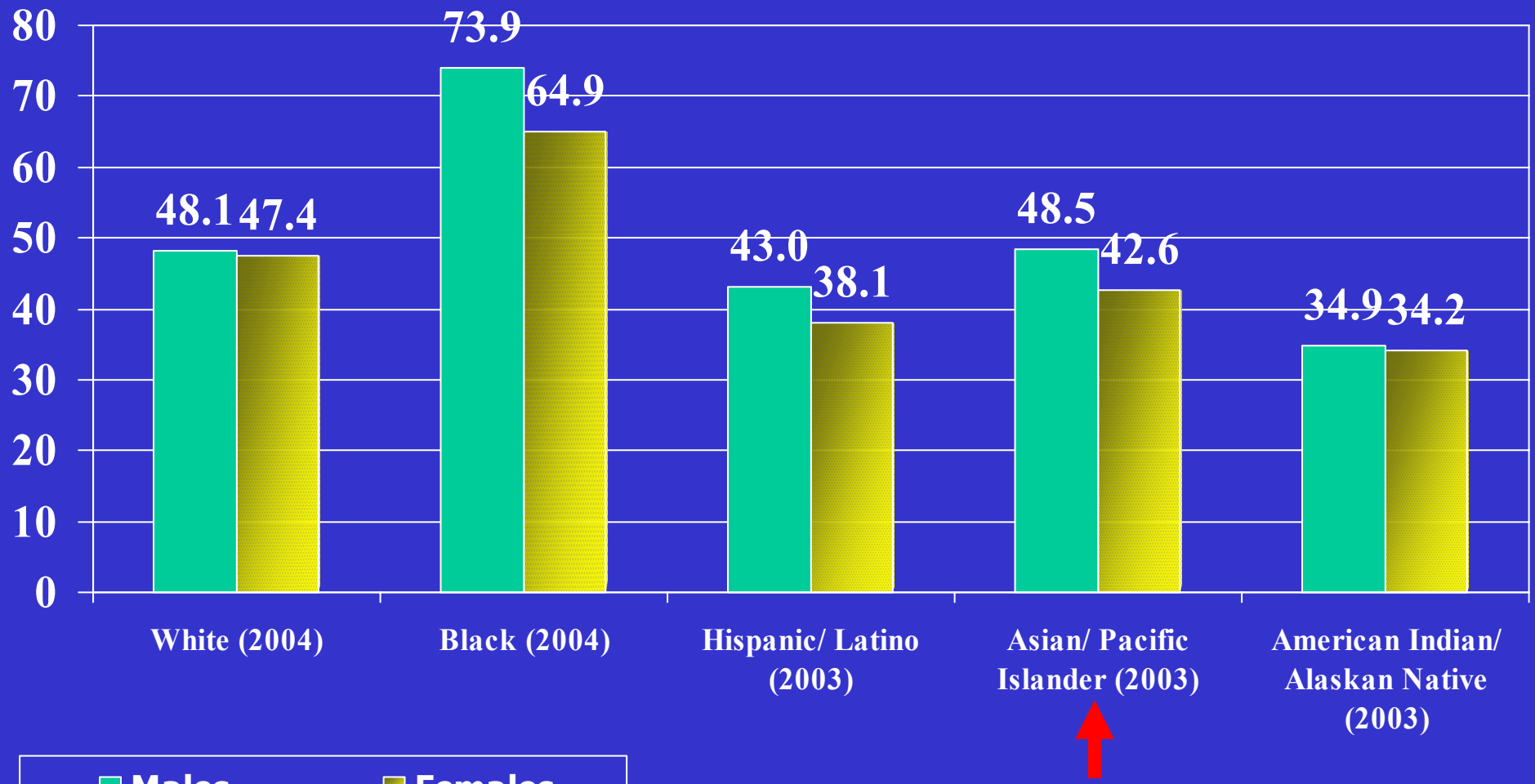
Stroke

Prevalence (%), Age 20+, U.S., 2004



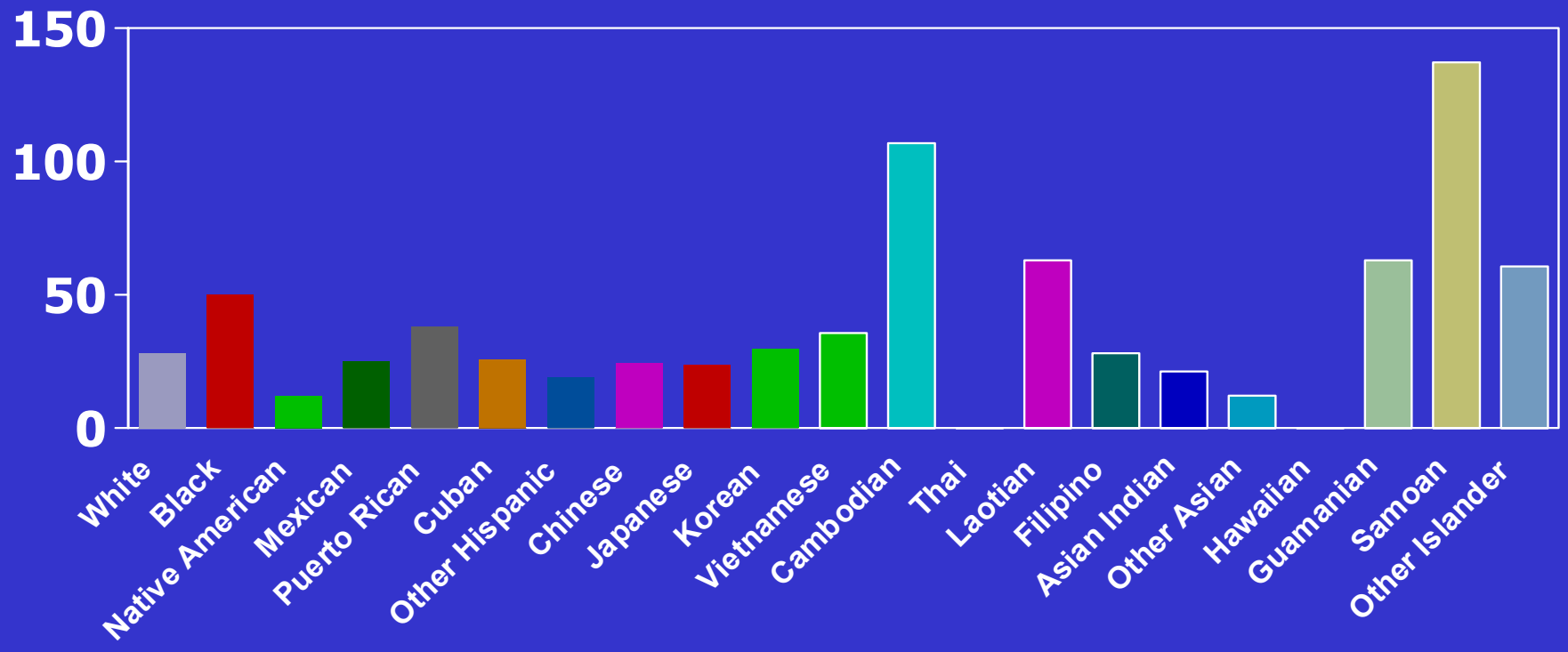
American Heart Association. (2007). Heart Disease and Stroke Statistics--2007 Update. *Circulation, 115*, e69-e171. Table 4-1.

Stroke Death Rates, U.S., 2003 & 2004



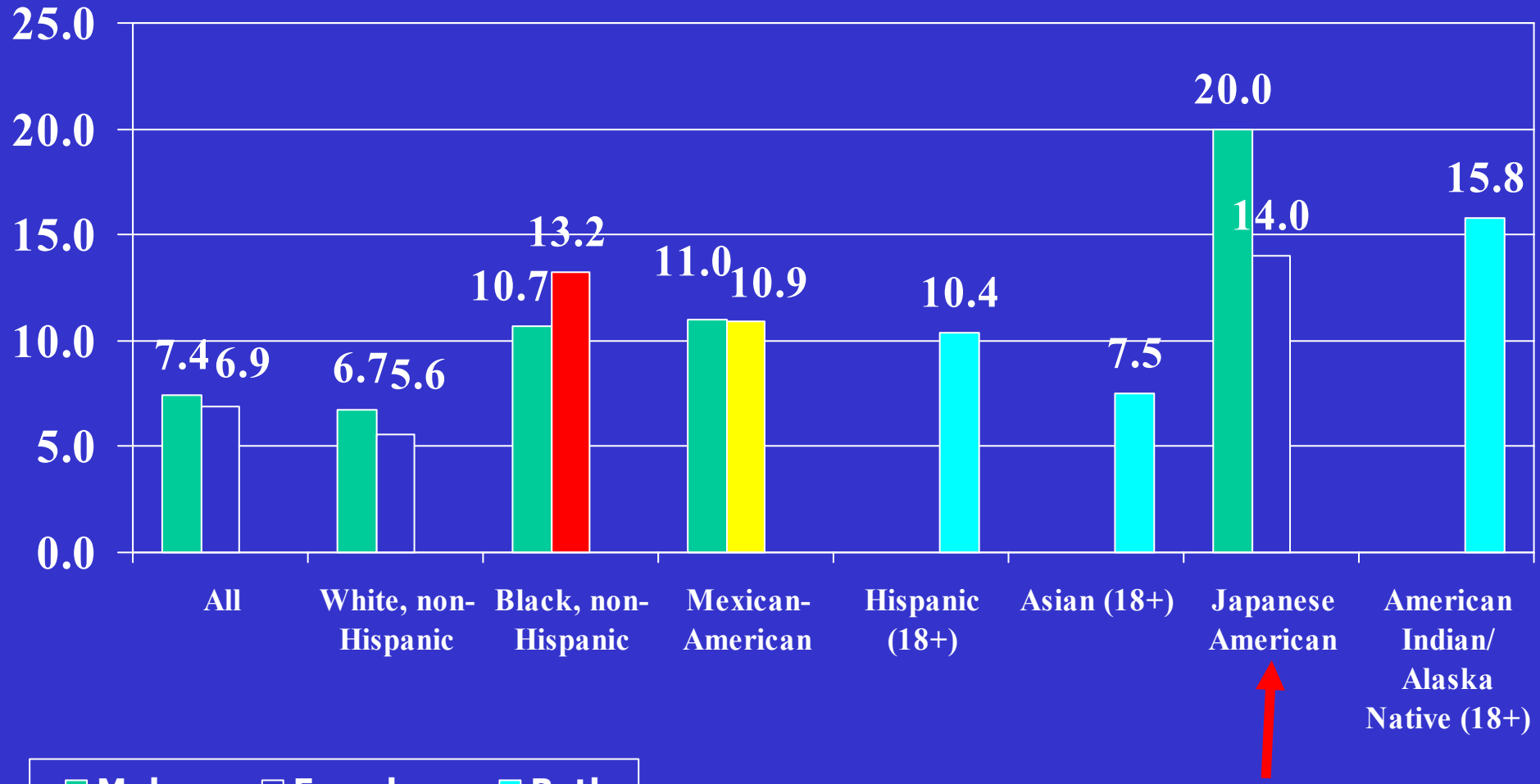
American Heart Association. (2007). Heart Disease and Stroke Statistics--2007 Update. *Circulation, 115*, e69-e171. E100.

Age-Adjusted Death Rates for Stroke, CA 1990



Physician-Diagnosed Diabetes

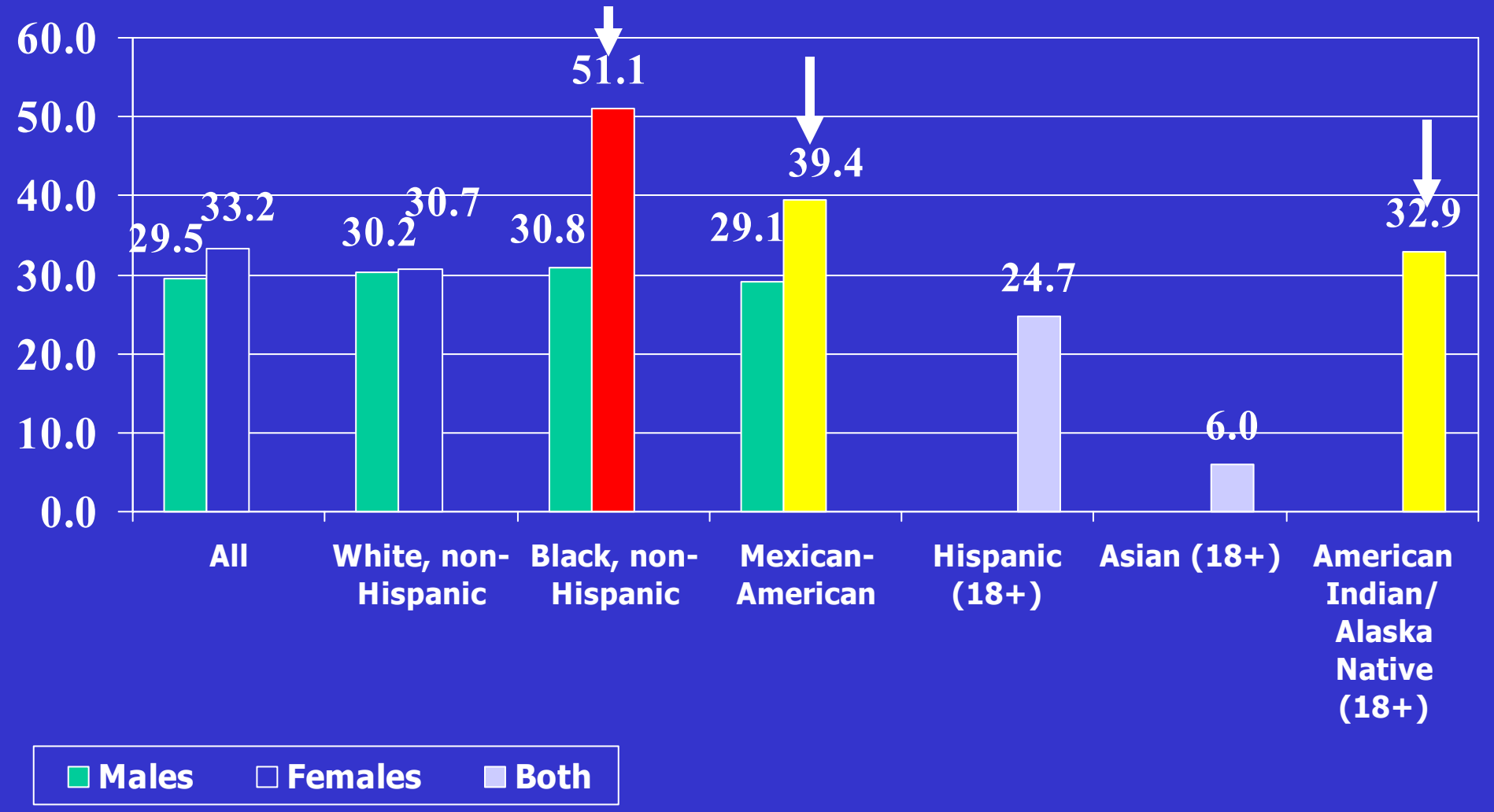
Prevalence (%), Age 18+, U.S., 2004



American Heart Association. (2007). Heart Disease and Stroke Statistics--2007 Update. *Circulation, 115*, e69-e171. Table 11-2.

Obesity (BMI 30+)

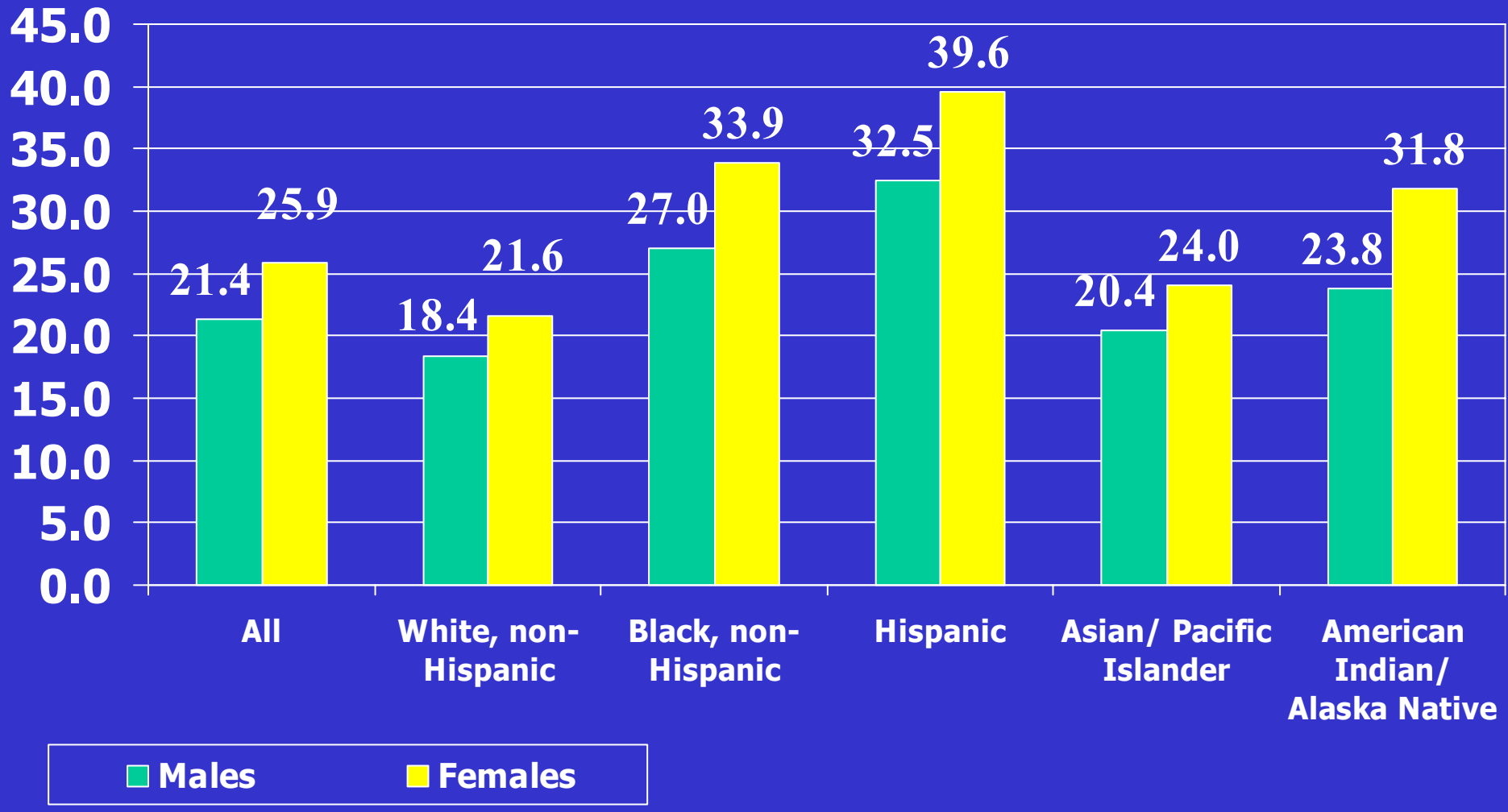
Prevalence (%), Age 20+, U.S., 2004



American Heart Association. (2007). Heart Disease and Stroke Statistics--2007 Update. *Circulation, 115*, e69-e171. Table 11-2.

Leisure-Time Physical Inactivity

Prevalence (%), Age 18+, U.S., 2004



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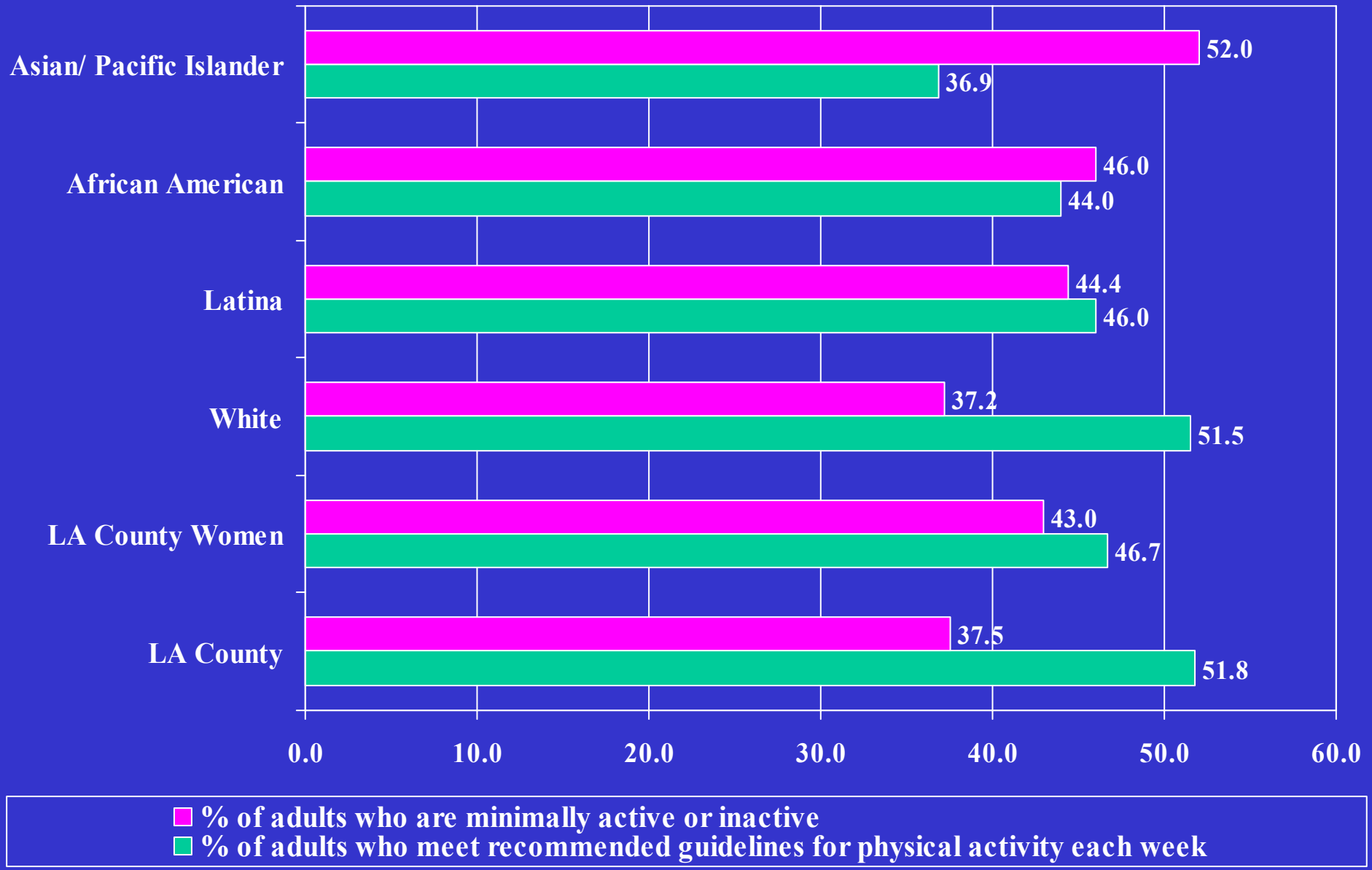
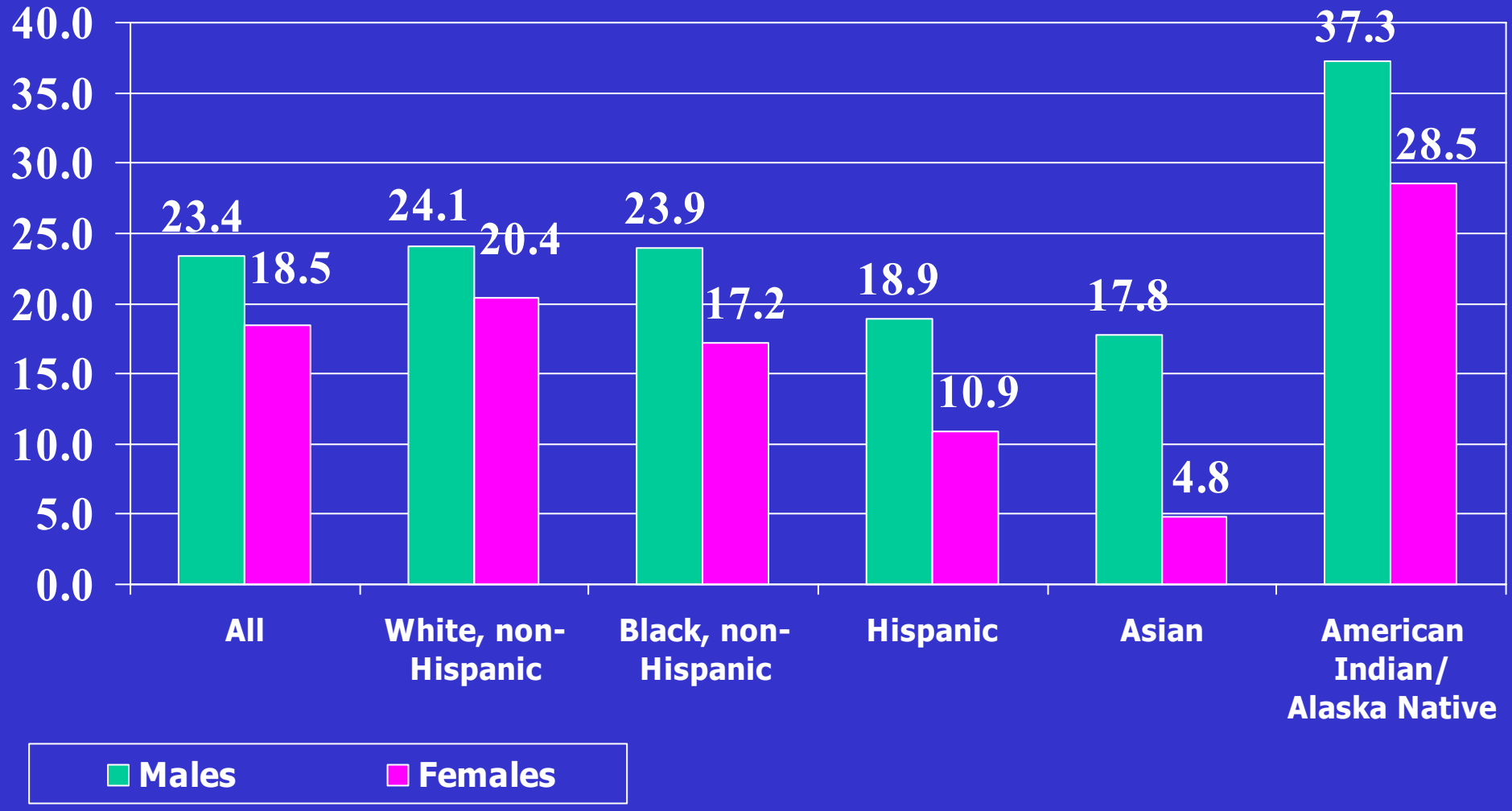
Physical Activity, LA County, 2005, Female



Los Angeles County Department of Public Health, Office of Women's Health (2007). *Health Indicators for Women in Los Angeles County: Highlighting Disparities by Ethnicity and Insurance Status*, May 2007.

Cigarette Smoking

Prevalence (%), Age 18+, U.S., 2004

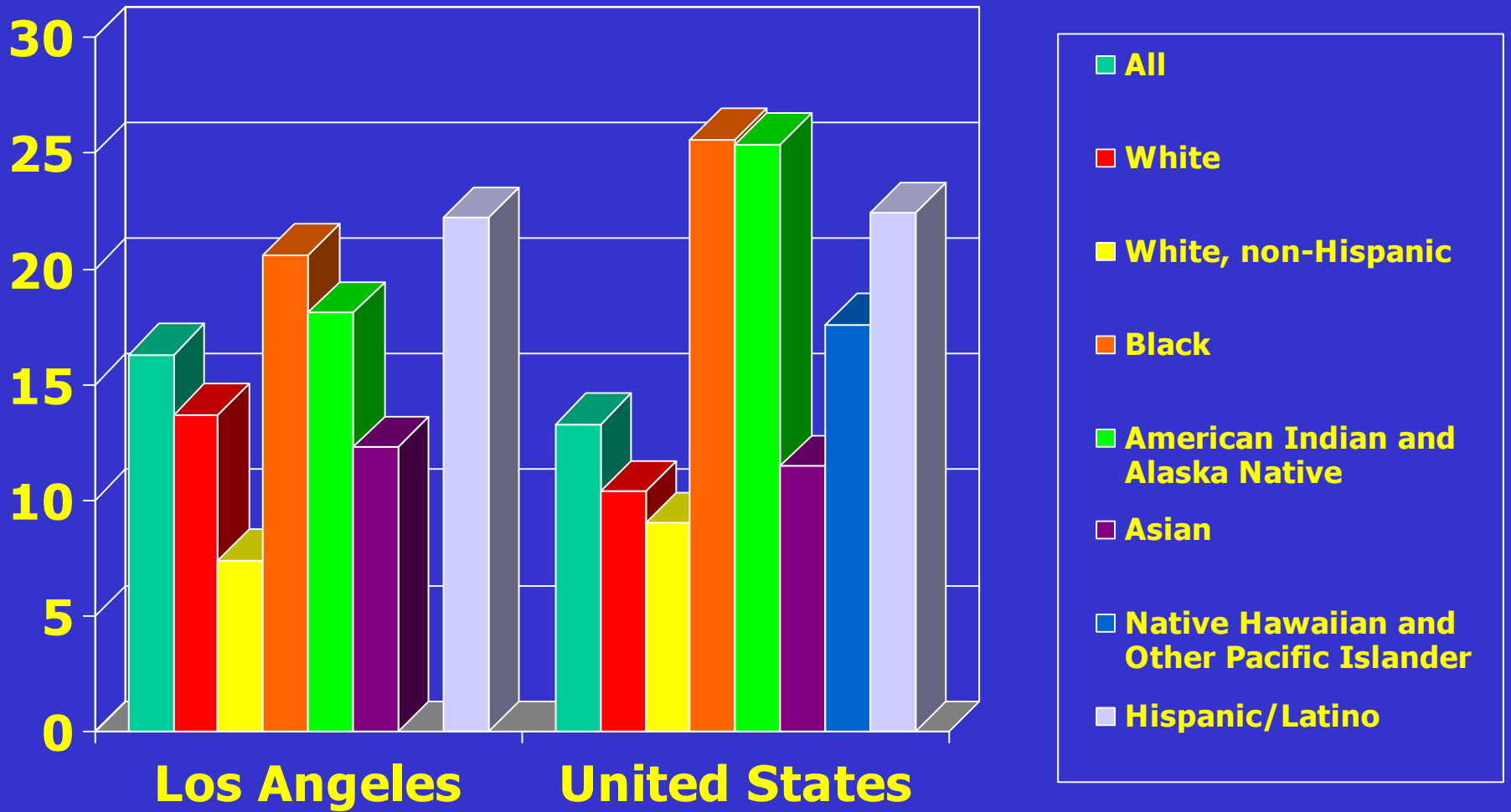


American Heart Association. (2007). Heart Disease and Stroke Statistics--2007 Update. *Circulation, 115*, e69-e171. Table 9-1.

Asian American Smoking rates

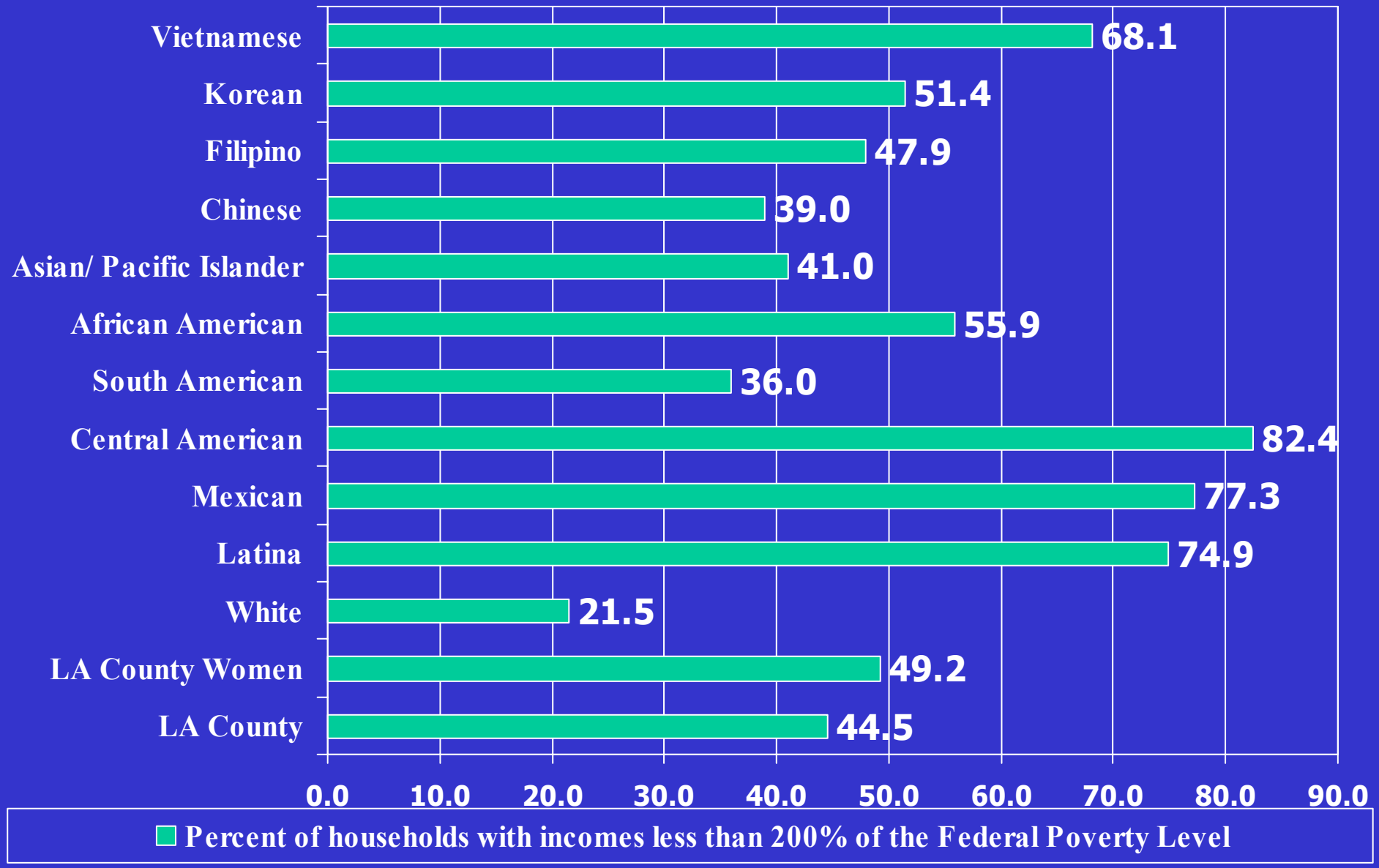
- US Average 30%
- Laotian 92%
- Vietnamese 67%
- Japanese 37%

Poverty Rates by Race and Hispanic Origin, LA and U.S., 2005



2005 American Community Survey

Poverty, LA County, 2003, Female



Los Angeles County Department of Public Health, Office of Women's Health (2007). *Health Indicators for Women in Los Angeles County: Highlighting Disparities by Ethnicity and Insurance Status*, May 2007.

How can we eliminate health disparities?

The Delivery Disconnect

Delivery = **Access to information and knowledge** → **Access to quality care**

→ **Critical Disconnect**

Prevention	Early Detection	Diagnosis/ Incidence	Treatment	Post Treatment/ Quality of Life	Survival and Mortality

Freeman, H.P., 2006

Poverty should NOT be an offense which is punishable by death.

Harold Freeman, 2007

Major Obstacles to Reduce Gaps in Morbidity & Mortality Worldwide (R. Hahn, 1999)

1. Poor allocation of resources, including misallocation and inefficient allocation **Discrimination and unequal access**

   Allocation based on gender, race/ethnicity, age, religion, socioeconomic status and region RATHER THAN suffering, efficacy and cost-effectiveness

2. Lack of commitment of needed resources by those who control them and/or those who control access to suffering populations
3. **Inadequate translation of public health knowledge into effective action** across the social and cultural boundaries between those who have resources and those who need them

Together these obstacles signify the lack of full *moral, economic, and* ***scientific*** *commitment* to the solution of critical public health problems

UNEQUAL AND UNNECESSARY BURDEN OF POOR HEALTH BORNE BY COMMUNITIES OF COLOR *(mks)*

Robert Hahn, Ph.D., MPH at the CDC

Anthropology in Public Health: Bridging differences in Culture and Society, 1999 p.4-5